

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-004693

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 38

FILED JAN 29 1963

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) INSTITUTION St. Marys Hosp.		d. STREET ADDRESS (If outside, give location) 265 Union Blvd.	
Length of stay in 1b HRS.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) DONALD M SUTOR			4. DATE OF DEATH Month Jan Day 4 Year 1963		
5. SEX Male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8/12/1874	9. AGE (last birthday) 88	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Joy Mfg. Co.		11. BIRTHPLACE (City and state or country) LaCrosse Wis.	
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME William A. Sutor		13b. MOTHER'S MAIDEN NAME Georgina McDonald	
14. NAME OF HUSBAND OR WIFE Charline S. Sutor		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Charline S. Sutor		18. CAUSE OF DEATH (Enter only one cause) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage arterio-sclerosis DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hours	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-but not related to the terminal disease condition given in PART I (a) gastro hemorrhage		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 11 a.m. 11/4/63 Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis COUNTY Mo. STATE Mo.		

21. I attended the deceased from 11/1/63 to 11/4/63 and last saw her alive on 11/4/63 Death occurred at about 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Thomas C. Indrzejewski M.D.		22b. ADDRESS 4660 Maryland		22c. DATE SIGNED 1/5/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 1/5/1963		23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
24. FUNERAL DIRECTOR Lupton Chapel		ADDRESS 7233 Delmar Blvd		25. DATE RECD. BY LOCAL REG. 1-5-63		26. REGISTRAR'S SIGNATURE John B. Murphy M.D.	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

VS 300
Rev. 4/59

1 **4005**

2 **2129**

3

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7 **1**

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9 **331X**

10

11

12 **46-0**

13

46

Sutor

4660 MARYLAND

Dr. Tom Birdsall

1.00 PM

9.00 a.m. to 1.00 Sat.

COUNTY

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Clarence A. Murray

Licensed Embalmer No. 4011

P. O. Address

H. Lewis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.